ICD 10–CM and ICD 10–PCS Preview
Diseases of the Skin and Subcutaneous Tissue
L00 to L99

- Infections of the skin and subcutaneous tissue (L00–L08)
- Bullous disorders (L10–L14)
- Dermatitis and eczema (L20–L30)
- Papulosquamous disorders (L40–L45)
- Urticaria and erythema (L49–L54)
- Radiation–related disorders of the skin and subcutaneous tissue (L55–L59)
- Disorders of skin appendages (L60–L75)
- Intraoperative and postprocedural complications of skin and subcutaneous tissue (L76)
- Other disorders of the skin and subcutaneous tissue (L80–L99)
Section 1.C.12. Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00–L99)

a) Pressure ulcer stage codes

1) Pressure ulcer stages: Codes from category L89, Pressure ulcer, are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer.

The ICD–10–CM classifies pressure ulcer stages based on severity, which is designated by stages 1–4, unspecified stage and unstageable.

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.
ICD 10–CM Official Coding Guidelines

2) Unstageable pressure ulcers: Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).

ICD 10–CM Official Coding Guidelines

3) Documented pressure ulcer stage:
 Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the Alphabetic Index.
 For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no documentation of the stage, the provider should be queried.
ICD 10–CM Official Coding Guidelines

4) Patients admitted with pressure ulcers documented as healed:

- **No code** is assigned if the documentation states that the pressure ulcer is completely healed.

5) Patients admitted with pressure ulcers documented as healing:

- Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage.
- **If the documentation is unclear** as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.
ICD 10-CM Official Coding Guidelines

6) Patient admitted with pressure ulcer evolving into another stage during the admission:

- If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, assign the code for the highest stage reported for that site.

ICD 10-PCS Coding Guidelines

- B3.5. Overlapping body layers
- If the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.

Example: Excisional debridement that includes skin and subcutaneous tissue and muscle is coded to the muscle body part.
ICD 10–PCS Coding Guidelines

- **B3.9 Excision for graft**
  - If an autograft is obtained from a different body part in order to complete the objective of the procedure, a separate procedure is coded.
  - *Example: Coronary bypass with excision of saphenous vein graft, excision of saphenous vein is coded separately.*

Character 6: Device

- *Depending on the procedure performed, there may or may not be a device left in place at the end of the procedure. The sixth character defines the device. Device values fall into four basic categories:*
  - Grafts and Prostheses
  - Implants
  - Simple or Mechanical Appliances
  - Electronic Appliances
- *If there is no device used in procedure, the value Z is used to represent NO DEVICE.*
Root Operation: Excision

- **Definition:** Cutting out or off, without replacement, a portion of a body part
- **Explanation:** Cutting out or off, without replacement, a portion of a body part
- **Includes/Examples:** Partial nephrectomy, liver biopsy, [excisional debridement per 3M C&RS selection and ICD 10–PCS Index]

Root Operation: Extraction

- **Definition:** Pulling or stripping out or off all or a portion of a body part by the use of force
- **Explanation:** The qualifier DIAGNOSTIC is used to identify extraction procedures that are biopsies
- **Includes/Examples:** Dilation and curettage, vein stripping; [non excisional debridement per 3M C&RS selections]
Root Operation: Replacement

- **Definition:** Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part.
- **Explanation:** The body part may have been taken out or replaced, or may be taken out, physically eradicated, or rendered nonfunctional during the REPLACEMENT procedure. A REMOVAL procedure is coded for taking out the device used in a previous replacement procedure.
- **Examples:** Total hip replacement, bone graft, free skin graft.

Root Operation: Supplement

- **Definition:** Putting in or on biologic or synthetic material that physically reinforces and/or augments the function a portion of a body part.
- **Explanation:** The biological material is non-living, or is living and from the same individual. The body part may have been previously replaced, and the Supplement procedure is performed to physically reinforce and/or augment the function of the replaced body part.
- **Examples:** Herniorrhaphy using mesh, free nerve graft, mitral valve ring annuloplasty, put a new acetabular liner in a previous hip replacement.
L76 Intraoperative & Post Procedural complications of skin and subcutaneous tissue

- **Intraoperative** hemorrhage and hematoma of skin and subcutaneous tissue complicating and procedure
- During a procedure
- Post Procedural hemorrhage and hematoma of skin and subcutaneous tissue **following a procedure**
  - L76.21 ..... Dematological procedure
  - L76.22 ..... Other procedure

Examine category L97

- L97 Non-Pressure chronic Ulcers of Lower Limb
  - Code first any associated underlying conditions
    - Six listed conditions
  - Code first any associated gangrene
  - Examine Note that describes under what circumstances L97 can be sequenced first.
Coding Exercises

1. Allergic Dermatitis; patient give penicillin for Strep throat.
   Prescription changed to Bactrim
   - T360X5A
   - L270
   - J020
   - Which code is listed first in ICD 10?
     - Effect (L270) or the drug (T360X5A)

2. Cellulitis in right lower leg
   - L03.115

Cellulitis, Right lower leg

ICD 10-CM/ICD 10-PCS Webinar Series --
Cypress College
Exercise #3

Diagnosis: Stage 3 large, pressure ulcer of the left buttock with gangrene; stage 2 pressure ulcer of the coccyx;

Procedures: Excisional debridement of stage 3 ulcer with full thickness skin graft to buttock; donor site was right thigh; Versajet debridement of Stage 2 ulcer

Questions:
1. What PCS Coding Guidelines apply?
2. What is the root operation for the excisional debridement?
3. What is the root operation for the FTSG?
4. What is the root operation for the Versajet debridement?
5. What is the root operation for obtaining the donor site tissue?
6. What is the principal diagnosis?
7. What is the principal procedure?
What is Versajet?

- One type of non-excisional debridement utilizes a Versajet device. A natural vacuum created by the jet stream removes tissue fragments. It allows the physician to debride, aspirate, and remove contaminants from wounds.
- AHA Coding Clinic, 3rd Quarter, 2009, pg. 13

Answers: Do you Agree?

- Diagnoses:
  1. I96 Gangrene, not elsewhere classified
  2. L89323 Pressure ulcer of left buttock, stage 3
  3. L89152 Pressure ulcer of sacral region, stage 2

- Procedures:
  1. 0JR907Z Replacement of Buttock Subcutaneous Tissue and Fascia with Autologous Tissue Substitute, Open Approach
  2. 0JB102Z Excision of Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach
  3. 0JB902Z Excision of Buttock Subcutaneous Tissue and Fascia, Open Approach
  4. 0HD62ZZ Extraction of Back Skin, External Approach
Calendar of Events

- April 19, 2012 @ 1:30 pm
  - ICD 10-CM/ICD 10-PCS Webinar
  - Chapter 13 Diseases of the Musculoskeletal System & Connective Tissue
- May 11, 2012 -- Save the Date -- Evening
  - GOCHIA Member Recognition Event @ Knotts Chicken Dinner Restaurant, Buena Park
- May 17, 2012 @ 1:30 pm
  - ICD 10-CM/ICD 10-PCS Webinar
  - Chapter 14 Diseases of the Genitourinary System
- May 17, 2012 @ 5:30 pm
  - Cypress College HIT Program Information Workshop
- June 10–13, 2012
  - CHIA Annual Conference
  - Santa Clara Convention Center & Hyatt Regency
  - Santa Clara, California

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This is to certify that
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has successfully completed

ICD 10-CM / ICD 10-PCS WEBINAR
CHAPTER 12 DISEASES OF SKIN & SUBCUTANEOUS TISSUE
1 Contact Hours on March 15, 2012

Rosalie Majid, RHIA

Rosalie Majid, RHIA, Director Health Information Technology Program
rmajid@cypresscollege.edu
714-484-7289